



SCAN/EMAIL COMPLETED REFERRAL TO cvicks@howardcountymd.gov . Please do not fax.

Referral Form for Cribs for Kids® Program and Car Seat Assistance Program

❖ CHECK WHICH PROGRAM (S) FAMILY IS BEING REFERRED TO:

Cribs for Kids® Program (no fee): _____ *Car Seat Assistance Program (\$35 fee)* _____

Date of Referral: _____ **Referring Agency:** _____

Contact Person/Phone #/Email: _____

Statement of Need (*brief description of family circumstances to support need*): _____

Recipient information:

Name of Mother/Guardian & DOB: _____

Address: _____

Home Phone #: _____ **Cell Phone #:** _____

Race: Asian _____ Black _____ White _____ Other _____ **Preferred Language:** _____

Ethnicity: Hispanic _____ Non-Hispanic _____

Baby's Due Date: _____ **OR Baby's Name & DOB:** _____

Insurance Information: Medical assistance #: _____ Other: _____

To be completed for Cribs for Kids® Program recipients only:

➤ **Environmental Smoke:**

_____ Mother smoked during pregnancy

_____ Mother will smoke after pregnancy (*Circle one:* inside or outside of the home)

_____ Members of household smoke (*Circle one:* inside or outside of the home)

➤ **Current Sleep Location:** Adult Bed _____ Other (specify) _____

➤ **Current Sleep Position:** Back _____ Stomach _____ Side _____

➤ **Is this a 1st time parent?** Yes _____ No _____ **How many other children in the home?** _____

For completion by Program Coordinator:

Date of phone contact with recipient: _____

Appointment date/time: _____